Request for Forms

Completion Instructions:

- **Quantity** – Indicate quantity requested in the **Quantity Ordered** column.
- **Shipping Address** – Type or print your GHP provider number, provider name, and address in the **FROM** box.
  NOTE: *We must have a* ***STREET ADDRESS;*** *UPS will not ship to a post office box.*
- **Mail this form to:** – GHP, P. O. Box 5000, McRae, GA 31055

Item	Form Type	Qty. Ordered
DMA-6	Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded	
DMA-44	Home Health Patient Profile	
DMA-59	Authorization for Nursing Facility Reimbursement	
DMA-69	Informed Consent for Voluntary Sterilization	
DMA-80	Prior Authorization Request	
DMA-81	Prior Approval for Medical Service	
DMA-276	Statement of Medical Necessity	
DMA-311	Certification of Necessity for Abortion	
DMA-380	Optical Device Prescription	
DMA-410	Third Party Liability (TPL) Confirmation Statement	
DMA-501	Adjustment	
DMA-520	Provider Inquiry Form	
DMA-521	Hospice Referral Form for Non-Hospice Related Services	
DMA-550	Newborn Medicaid Certification	
DMA-610	Prior Authorization Request	
DMA-613	Level I Applicant/Resident I.D. Screening Instrument	
DMA-615	ESRD Enrollment Application	
DMA-632	Presumptive Eligibility Determination for Pregnancy-Related Care	
DMA-633	Change Form /Temporary Medicaid Card	
DMA-634	Notice of Action	
DMA-635	Post Partum Home Visit Mother Assessment	
DMA-637	Post Partum Teaching Guide	
DMA-638	Letter of Understanding	
DMA-639	Model Waiver Assessment	
DMA-641	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7 month visit)	
DMA-642	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11-12 month visit)	

FROM											
	Provider Medicaid ID Number (10-digits)										
	Provider Name										
	Street Address										
	City, State, Zip Code										

DMA 292 (Rev. 6/01)